Welcome to our office

Please print the following valuable information to help us serve you better.

Name ______________________________ E-mail ______________________

Address ____

City / State / Zip ____

Home # ________________ Cell# ________________ Work # ________________

Occupation ____________________ Employer ______________________

Age ____ Birth Date ______ Social Security # __________ Marital Status: ❑ S ❑ M ❑ D ❑ W

Primary Health Insurance Plan ____________________ Policy # ________________

Secondary Insurance ____________________ Vision Plan ________________

Insured Name ______________ Insured Birth Date ________ I.D. # ______________

GENERAL HEALTH	YES	NO	IN FAMILY
High Blood Pressure			
Diabetes			
Heart Disease			
Thyroid			
Headaches			
Arthritis			
Cancer			
Allergy / Sinus			

EYE HISTORY	YES	NO	IN FAMILY
Glaucoma			
Cataracts			
Lazy Eye			
Eye Surgery			
Eye Injuries			
Macular Degeneration			
Retinal Detachment			
Color Blindness			

CURRENT VISION PROBLEMS	YES	NO
Blur at Distance		
Blur at Near		
Double Vision		
Floaters		
Flashing Lights		
Eye Pain		
Eyes Itch or Burn		
Eyes Tear		

Do you smoke? ❑ Yes ________/ packs per day ❑ No

Do you drink alcohol? ❑ Yes ________/ drinks per week ❑ Socially only ❑ No

Current medications: ____

Are you allergic to any medications? ❑ Yes ❑ No (specify) ______________________

Medical Doctor ______________________________ Phone # ________________

Last Eye Exam (date) ______________ Doctor's Name ______________________

Do you wear Glasses? ❑ Yes ❑ No Contact lenses? ❑ Yes ❑ No Type ______________

Are you interested in Contact Lenses? ❑ Yes ❑ No Glasses? ❑ Yes ❑ No

How were you referred to us? ______________________________________

Dilation Procedures: Dilation includes use of topical medication to dilate the pupil to facilitate a complete view of the eye, to detect disease.

Advisement: Wear dark sunglasses after the procedure. Near vision will be blurred for approximately 2 hours. Eyes will be sensitive to light. Care should be taken when driving as some people experience blur at distance after dilation.

Assignment and Release: I hereby authorize the physician to release any information required to process this claim. I also authorize my insurance benefits to be paid directly to the physician and I understand that I am financially responsible for all non covered services.

Patient Signature: ______________________________________ Date: __________

– PAYMENT IS DUE WHEN PROFESSIONAL SERVICES RENDERED –